NEW PATIENT DEMOGRPHIC INFORMATION
TRIBECA PARK DERMATOLOGY

Patient Name ______________________________

Street Address ______________________________

City ______________ State ______________ Zip Code ______________

Telephone (mobile) ______________ (work) ______________

Email address ______________________________

**By providing my email address I give you permission to send me appointment reminders and promotional emails about new or discounted services and specials. I understand that I may unsubscribe at any time, and that you will never sell or share my email with any external entity.*

[ ] Check here if you do NOT want to receive newsletters or promotional emails.

Date of Birth ______________

Birth Sex ______________ Gender Identity ______________ Pronoun(s) ______________

Relationship Status Single Married Partnered Other

Name of Spouse/Partner ______________________________

Emergency Contact Name ______________ Relationship ______________

Emergency Contact Phone Number ______________________________

Name of Employer ______________________________

Who Referred You? ______________________________

What is the name of your Primary Care Physician? ______________________________

What is the name of your Insurance Carrier? ______________________________

Name of the Primary Policy Holder (if other than self)? ______________ DOB______________

Pharmacy ______________ Address/Telephone ______________

I understand that all medical costs incurred by me are my responsibility; including any charges my insurance fails to pay. I also understand that I am responsible for any collection and/or legal efforts that may be necessary on my account. I authorize payment of medical benefits to the physician for services provided.

Signature of Patient______________________________ Date______________